AGENDA

BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES
ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

TUESDAY, FEBRUARY 1, 2011
STATE CAPITOL, ROOM 4202
1:00 P.M.

EVERY EFFORT WILL BE MADE TO ACCOMMODATE ALL MEMBERS OF THE PUBLIC WHO WISH TO PROVIDE PUBLIC TESTIMONY. HOWEVER, DUE TO THE UNUSUALLY SHORT TIME-FRAME AND THE BREADTH OF HEALTH AND HUMAN SERVICES ISSUES BEING CONSIDERED, THE CHAIR WILL ANNOUNCE AT THE ONSET OF EACH HEARING HOW MUCH TIME, AND WHERE IN THE AGENDA, PUBLIC TESTIMONY WILL BE ALLOWED. WRITTEN TESTIMONY IS STRONGLY ENCOURAGED, AS THE SUBCOMMITTEE CANNOT GUARANTEE THERE WILL BE ENOUGH TIME FOR EVERYONE TO SPEAK.

4280 MANAGED RISK MEDICAL INSURANCE BOARD

OVERVIEW

The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers five programs as follows:

1. **The Major Risk Medical Insurance Program (MRMIP).** MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP. The budget proposes no policy changes for MRMIP.

2. **Access for Infants and Mothers (AIM).** AIM provides low cost insurance coverage to uninsured, low-income pregnant women. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Cigarette and Tobacco Product Surtax Funds deposited into a special account, as well as federal funds to supplement the participant's contribution to cover the cost. The budget proposes no policy changes for AIM.

3. **County Children's Health Initiative Matching Fund Program (CHIM).** The CHIM offers counties the opportunity to use local funds to obtain federal matching funds for their Healthy Children's Initiatives, which provide health coverage to uninsured children. Currently, four counties participate in CHIM. The budget proposes no policy changes to CHIM.

4. **Pre-Existing Conditions Insurance Program (PCIP).** PCIP offers health coverage to medically uninsurable individuals 18 years or older who live in California. It is available for people who have not had health coverage in the 6-months prior to applying. PCIP uses a preferred provider network that has contracted health providers in all 58 counties statewide. Monthly premium costs are based on the applicant's age and the region where the applicant lives.

5. **Healthy Families Program.** The HFP provides subsidized health, dental and vision coverage through managed care arrangements for children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements. Eligibility is conducted on an annual basis. A 65 percent federal match is obtained through a federal allotment (Title XXI funds). The HFP is not an entitlement program.

Summary of Proposed Budget. The budget proposes total expenditures of $1.5 billion ($267.5 million General Fund) for all programs administered by the MRMIB for 2011-12 as shown in the chart below.

Summary of MRMIB Expenditures (dollars in thousands)	2010-11	2011-12	$ Change
Major Risk Medical Insurance Program	$51,527	$37,084	-$14,443
Access for Infants & Mother	$123,953	$122,465	-$1,488
Healthy Families Program	$1,125,440	$1,054,124	-$71,316
County Health Initiative Program	$1,764	$1,773	-$9
Pre-Existing Conditions Plan Program	$217,372	$341,376	$124,004
Totals Expenditures	**$1,520,056**	**$1,556,822**	**-$36,766**
General Fund	$130,801	$267,469	$136,668
Federal Funds	$796,737	$749,563	-$47,174
Federal Funds—High Risk Health Insurance	$217,372	$341,376	$120,004
Children's Health & Human Services Special	$176,841	$97,226	-$79,615
Managed Risk Medical Insurance Fund	$51,527	$37,084	-$14,443
Other Funds	$146,778	$64,104	-$82,674

HEALTHY FAMILIES PROGRAM

Background. In addition to children up to 250% FPL, infants born to mothers enrolled in the AIM Program (200 to 300 percent of poverty) are immediately enrolled into the HFP and can remain under the HFP until age two. When these AIM-to-HFP babies reach two-year olds, those who are in families that exceed the 250 percent federal income level are no longer eligible to remain in the HFP.

Table: Summary of Eligibility for Healthy Families Program

Type of Enrollee	Income Level	Comments
Infants up to the age of two years who are born to women enrolled in Access for Infants & Mothers (AIM).	200% to 300%	• For income from 200% to 250%, coverage through age 18. • For income above 250%, coverage up to age 2.
Children ages one through 5 years	133% to 250%	Healthy Families Program covers from 133 percent and above because children below this are eligible for Medi-Cal.
Children ages 6 through 18 years	100% to 250%	Healthy Families Program covers children in families above 100%. Families with two children may be "split" between programs due to age.

Children enrolled in County "Healthy Kids" programs cover children without residency documentation and children from 250% to 300% FPL.	Not eligible for HFP, including 250% to 300%.	State provides federal funds to county projects as approved by the MRMIB. Counties provide the match for the federal funds.

Benefits. The HFP benefit package is modeled after that offered to state employees, including health, dental and vision. The enabling federal legislation—the Children's Health Insurance Program (CHIP)—required states to use this "benchmark" approach. These benefits are provided through managed care arrangements. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but consumer choice has always been available.

In addition to these HFP benefits, enrolled children can also access the California Children's Services (CCS) Program if they have a CCS-eligible medical condition. A child enrolled in the HFP is also eligible to receive supplemental mental health services provided through County Mental Health Plans. These additional services are provided in accordance with state statute and are also available to children enrolled in Medi-Cal.

Enrollment. The HFP experienced a significant drop in enrollment between June 2009 and June 2010. It is impossible to know with certainty the cause or causes for this drop, however the MRMIB staff point out that an enrollment freeze, and waiting list, were instituted in June 2009, due to insufficient funding in the program. While subsequent augmentations were provided, and the waiting list ended, it's possible that some families have not returned. It's also possible that due to economic circumstances, some families' incomes have dropped thereby making them eligible for Medi-Cal. Advocates state that the drop, at least in part, reflects the recent increases in premiums in the program; however, the MRMIB states that they did not see a large drop in enrollment after the last premium increase.

Summary of Proposed Budget. A total of $1.044 billion ($264.8 million General Fund) is proposed for 2011-12 to provide health care coverage to an estimated 916,029 children. This proposed funding level reflects a series of cost-containment proposals as shown in the table below. Each of these issues is discussed in detail below.

Table: Proposed Reductions to the Healthy Families Program

Budget Proposals	Effective Date	2010-11		2011-12	
		GF	Total	GF	Total
Eliminate Vision Coverage	June 1, 2011	-$900,000	-$2.6 m	-$11.3 m	-$32.3 m
Increase Premiums	June 1, 2011	-$1.9 m	-$5.3 m	-$22.2 m	-$63.3 m
Increase Co-Pays for Emergency Room Visits & In-Patient Hospital Stays	October 1, 2011	0	0	-$5.5 m	-$15.9 m
Subtotal Subscriber Changes		**-$2.8 m**	**-7.9 m**	**-$39 m**	**-$111.5 m**
Managed Care Plan Tax	July 1, 2011	0	0	-$97.2 m	-$97.2 m
Total Proposals		-$2.8 m	-$7.9 m	-$136.2 m	-$208.7 m

ISSUE 1: ELIMINATION OF HFP VISION COVERAGE

Budget Proposal. The budget eliminates vision coverage for children for a reduction of $2.6 million ($900,000 General Fund) in 2010-11, and $32.3 million ($11.3 million General Fund) in 2011-12.

Additional Details:

- The Administration assumes enactment of legislation by March 1, 2011 for implementation to be effective by June 2011. Families need to be notified of the elimination of the coverage and the contracts with the Vision Plans would need to be closed-out.
- This proposal requires federal approval for implementation.

Background. Currently, HFP provides vision coverage through a separate Vision Plan, as done in the employer-based insurance market. There are three Vision Plans for HFP subscribers to choose from, including: 1) Vision Service Plan (VSP); 2) EyeMed Vision Care; and, 3) SafeGuard vision. About 900,000 children are presently enrolled in a Vision Plan.

According to the MRMIB, Vision Plan coverage includes the following services:

- Case History;
- Evaluation of the health of the visual system including:
  - External and internal examination;
  - Assessment of neurological integrity;
  - Biomicroscopy of the anterior segment of the eye;
  - Screening of gross visual fields; and
  - Pressure testing through tonometry.
- Binocular function test;
- Diagnosis and treatment plan, if needed;
- Corrective lenses, limited to once each twelve consecutive month period; and,
- Contacts are covered with prior authorization and under certain conditions, such as cataract surgery.

If vision coverage were eliminated, a more limited set of sensory vision services would remain available. The HFP Health Plan benefit includes some preventive vision services, including some vision testing, eye refractions to determine the need for corrective lenses, and dilated retinal eye exams.

California's Knox Keene Act requires Health Plans to "provide benefits for the comprehensive preventive care of children 16 years of age or younger" that comply with recommendations for preventive pediatric health care, as adopted by the American Academy of Pediatrics; these sensory Vision screenings are to be performed at ages 3 to 6, 8, 10, 12, 15 and 18 years. Further, medically necessary services for the

treatment of eye illnesses or eye injuries would also be provided under the HFP Health Plan benefit. Annual eye exams and glasses would not be covered by Health Plans. Out-of-pocket cost for a pair of frames and lenses for a child is estimated to be approximately $70.

LAO. The LAO recommends approval of the Administration's proposal to eliminate the Vision benefit due to the State's fiscal condition and since it is not a required benefit of the federal CHIP program.

STAFF COMMENTS & QUESTIONS

The Governor proposed this last year, at which time the Legislature was told that a new, lower cost benefit was being developed by one of the Vision Plans. According to the MRMIB, that benefit package is still being worked on at this time. Some alternatives that would achieve savings, though less than from full elimination, include:

- Requiring HFP health plan to offer some of these services, such as just vision exams;

- Requiring HFP health plans to contract directly with vision plans to offer these services at a potentially lower cost; and

- Exploring the provision of these services by Medi-Cal, which purchases frames and lenses from the Prison Industries Authority.

ISSUE 2: INCREASES TO HFP PREMIUMS

Budget Proposal. The budget significantly increases the monthly premiums paid by families with incomes from 151 percent up to 250 percent for total savings of $5.3 million ($1.9 million General Fund) in 2010-11, and $63.3 million ($22.2 million General Fund) in 2011-12.

Additional Details:

- The Administration assumes enactment of legislation by March 1, 2011 for implementation to be effective by June 2011.
- A State Plan Amendment must be approved by the federal CMS for this purpose.

Federal approval is necessary to: 1) Ensure California conforms to federal requirements regarding family cost sharing (premiums and co-pays cannot exceed 5 percent of family income); and 2) Ensure the proposed premium increases would not violate federal maintenance of effort (MOE) provisions as contained in the federal Patient Protection and Affordable Care Act (Affordable Care Act) of 2010. The table below provides a summary of the proposed premium changes. Premiums were increased in 2005 and twice in 2009.

Table: Proposed Monthly Premium Increases

HFP Subscriber Family Income %	Existing Monthly Premium	Proposed Increase to Premiums	Proposed Revised Monthly Premium (effective June 1, 2011)
100 to 150% (Category "A")	$7 per child Family Maximum of $14	No change Federal law prohibits	No change Federal law prohibits
151 to 200% (Category "B")	$16 per child Family Maximum of $48	$14 per child Family Maximum of $42	$30 per child Family Maximum of $90
201 to 250% (Category "C")	$24 per child Family Maximum of $72	$18 per child Family Maximum of $54	$42 per child Family Maximum of $126

Monthly premiums for families from 151 percent to 200 percent of poverty (Category B) would be increased by $14 per child, or by 87 percent, for a total of $30 per child per month, with a family maximum of $90 for three or more children. The increase to Category B families results in an expenditure reduction of $35.7 million ($12.5 million General Fund) to the HFP.

Monthly premiums for families from 201 to 250 percent of poverty (Category C) would be increased by $18 per child, or by 75 percent, for a total of $42 per child per month, with a family maximum of $126 for three or more children. The increase to Category C

families results in an expenditure reduction of $27.6 million ($9.7 million General Fund) to the HFP.

Federal Maintenance of Effort (MOE) Requirement. The Affordable Care Act of 2010 requires States to retain current income eligibility levels, including processes and procedures for enrollment, for children in CHIP programs. States that violate the MOE risk losing all federal funds for both their CHIP and Medicaid programs.

Two federal CMS letters—one to California and the other to Georgia—suggest that CMS views increases to premiums as likely to violate these federal MOE provisions. However, there is disagreement over the interpretation of these letters and the CMS's position is not at all certain. Nevertheless, at risk to California is over $750 million in federal funds within the HFP, as well as over $26 billion in federal funds within the Medicaid Program (Medi-Cal).

Federal Law Limits Cost-Sharing Amounts Charged to 5 Percent. Federal law imposes limits on the total aggregate amount of all cost-sharing, including premiums and co-payments, at a maximum of 5 percent of family income on a monthly basis. According to MRMIB, the federal CMS has communicated that the closer the cost-sharing imposed on families gets to the 5 percent threshold, the more likely the federal CMS will require MRMIB and participating Health Plans to directly track and monitor individual family out-of-pocket expenses, a costly enterprise for the State and participating Health Plans, if ever required.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- Federal CMS approval of premium increases is uncertain, at best.
- The proposed premium increases are substantial for low-income families. The Category B premiums reflect an increase of 87 percent, and the Category C premiums reflect an increase of 75 percent. These percentages likely would draw public outrage in the private insurance market. The MRMIB states that while these are high percentage increases, in their view the premiums are still relatively low.
- The Administration's cost savings estimate for the premium increases does not assume any reductions to caseload. Due to the level of increase, it seems likely that some families will drop HFP coverage due to cost.

1. What is the viability of the federal CMS to approve any premium increases within the context of California meeting its MOE provisions?

2. Would the Administration provide alternative savings estimates based on smaller premium increases?

ISSUE 3: INCREASES TO HFP CO-PAYMENTS

Budget Proposal. The budget projects savings of $15.9 million ($5.5 million General Fund) by increasing HFP copayments to conform to a similar proposal within Medi-Cal. The co-payments include:

- Emergency Room visits which do not result in hospitalization or outpatient observation would increase from $15 to $50; and

- Hospital Inpatient days would have a co-pay of $100 per day (maximum of $200 per stay).

Additional Details:

- An October 1, 2011 implementation date is assumed.
- This proposal requires federal approval through a State Plan Amendment, as well as a federal Waiver.

Background. In addition to monthly premiums, families also must provide co-payments for their children to receive services. Co-payments count towards the federal cost-sharing maximum of five percent of monthly family income.

As of November 2009, copayments were increased for families with incomes from 150 percent to 250 percent as follows:

- Non-preventive health, dental, and vision services—from $5 to $10.
- Generic prescription drugs—from $5 to $10.
- Brand name prescription drugs-- $5 to $15, unless no generic is available or brand name drug is medically necessary.
- Emergency room visits—from $5 to $15, unless child is admitted to hospital.

Existing statute and HFP regulation have a cap of $250 annually (per family) on the amount of out-of-pocket co-payments. It is up to families to track this information and if the cap is reached, the family informs the HFP that it has been reached.

The MRMIB notes that the $250 annual copayment cap would not be modified under this proposal in order to meet the existing federal requirement of not exceeding 5 percent of a family's income in all cost-sharing arrangements (meaning premiums and co-pays collectively).

ISSUE 4: PRE-EXISTING CONDITION INSURANCE PROGRAM REQUEST

Budget Proposal. MRMIB requests an increase of $3.5 million (federal funds) to support 28 positions and external contract expenditures to continue implementation and operation of California's Pre-Existing Condition Insurance Program (PCIP) as recently authorized in both federal and State statute.

California received federal approval in August 2010, along with an allocation of $761 million (federal funds) to operate a high-risk health insurance pool (PCIP in California). The federal Department of Health and Human Services (DHHS) will reimburse MRMIB for administrative expenses and claims for covered medical services that are in excess of the premiums collected from enrollees in the PCIP.

MRMIB states that by the nature of the program phasing-out, the positions will also phase-out as of June 30, 2014.

Background. The Affordable Care Act of 2010 established a temporary federal high-risk pool program (June 2010 through December 31, 2013) and provided States flexibility to operate their own program. SB 227 (Alquist), Chapter 31 of 2010 and AB 1887 (Villines), Chapter 32 of 2010 required the MRMIB to establish and administer California's program. Implementation was contingent on an agreement with the federal government and receipt of adequate federal funds for this purpose. The legislation prohibits the use of any State funds for this new federal program and continuously appropriates the federal funds. As such, the MRMIB has already administratively established these positions

PCIP is governed by terms of a contract with the federal DHHS, which was approved in August 2010. An allocation of $761 million (federal funds) was provided for California to operate the program.

PCIP offers health coverage to medically uninsurable individuals 18 years or older who live in California. It is available for people who have not had health coverage in the 6-months prior to applying. PCIP uses a preferred provider network that has contracted health providers in all 58 counties statewide. Monthly premium costs are based on the applicant's age and the region where the applicant lives.

4250 CALIFORNIA CHILDREN AND FAMILIES PROGRAM

ISSUE 1: PROPOSITION 10 FUNDS SHIFT TO MEDI-CAL

Budget Proposal. The Governor's budget proposes to:

1. Use $1 billion (Proposition 10 Funds) to fund Medi-Cal services for children (aged five and under) to offset General Fund support in the program for 2011-12; and

2. Transfer, beginning July 2012, fifty percent of local Proposition 10 Funds to a new Special Fund to support Medi-Cal services for children (aged five and under) on an on-going basis. The Administration estimates this will amount to approximately $200 million annually.

Of the $1 billion (Proposition 10 Funds) for 2011-12, the Department of Finance (DOF) assumes that approximately $233.9 million is obtained from the State Commission and the remaining amount of $766.1 million is obtained from local commission reserves. However, the amounts from the State Commission and local commissions may be adjusted based upon pending updated information.

Additional Details:

- A new Special Fund—Proposition 10 Health and Human Services Fund (4260-101-3148)—has been established in the Budget Bill for this purpose.
- This proposal requires voter approval. A June 2011 ballot initiative is assumed.

Background. The California Children and Families Program (also known as "First 5") was created in 1998 upon voter approval of Proposition 10, the California Children and Families First Act. There are 58 county First 5 commissions as well as the State California and Families Commission (State Commission), which provide early development programs for children through age five. County commissions implement programs in accordance with local plans to support and improve early childhood development in their county. While programs vary from county to county, each county commission provides services in three main areas: 1) Family Functioning; 2) Child Development; and 3) Child Health. Funding is provided by a Cigarette Tax (50 cents per pack), of which about 80 percent is allocated to the county commissions, and 20 percent is allocated to the State Commission.

Reserves. Unspent funds are carried over for use in subsequent fiscal years. According to the DOF, over time, both the State and local fund balances have grown. The DOF contends as of June 30, 2009, county commissions held more than $2 billion in reserves.

County commissions state that the amount of reserve assumed by the DOF is too high since some County commissions have maintained prudent reserves for their future obligations. They note that any redirection could create job loss and disruption, and eliminate some vital services that are provided at the local level.

After a similar proposal two years ago, Proposition 1D was placed on a special statewide May 2009 ballot to redirect a portion of Proposition 10 Funds to support certain state health and human services programs. It was unsuccessful.

LAO. In previous analyses, the LAO has recommended a redirection of Proposition 10 Funds to support certain health and human services programs. They noted that Proposition 10 was approved by voters during a healthier fiscal period for California, and with the State facing continued hardship with the recession, it would make fiscal sense to prioritize core children's programs.

STAFF COMMENTS & QUESTIONS

1. Please describe what the impact will be on local commissions and on the local programs currently supported with Proposition 10 funds.

4260 DEPARTMENT OF HEALTH CARE SERVICES

OVERVIEW

The federal Medicaid Program (Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. Medi-Cal is at least three programs in one: 1) a source of traditional health insurance coverage for low-income children and some of their parents; 2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness; and 3) a wrap-around coverage for low-income Medicare recipients ("dual" eligibles who receive Medicare and Medi-Cal services).

Medi-Cal Eligiblility and Enrollment. Generally, Medi-Cal eligibles fall into four categories of low-income people as follows: 1) aged, blind or disabled; 2) low-income families with children; 3) children only; and 4) pregnant women. Men and women who are not elderly and do not have children or a disability cannot qualify for Medi-Cal no matter how low their income. Low-income adults without children must rely on county provided indigent health care, employer-based insurance, out-of pocket expenditures or a combination of these.

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others at the state's option.

Estimated Medi-Cal enrollment for the current year is 7.5 million and 7.7 million for 2011-12. Medi-Cal provides health insurance coverage to almost 20 percent of Californians and almost 24 percent of insured Californians. Most Medi-Cal clients are from households with incomes at or below 100 percent of poverty ($18,310 annually for a family of three).

Summary of Proposed Budget. As shown in the table below, the Governor proposes total expenditures of almost $42.5 billion ($13.8 billion General Fund, $26 billion federal Title XIX Medicaid funds, and $2.7 million in other funds) for Medi-Cal in 2011-12. This reflects a proposed decrease of almost $13.2 billion (total funds), or 23.7 percent, as compared to the revised 2010-11 budget. There are several key aspects to this significant reduction proposed by the Governor, which are discussed below.

First, the significant change in federal funding. Both the federal American Recovery & Reinvestment Act (ARRA) of 2009, and the Education, Jobs and Medical Assistance Act of 2010, provided States with enhanced federal funding for their Medicaid programs. For California, the enhanced federal funding provided almost $3 billion in General Fund relief within the DHCS Medi-Cal Program for 2010-11. However, the loss of this federal support (enhanced funding ends June 30, 2011) is estimated to increase General Fund support by $2.544 billion in 2011-12.

Medi-Cal Funding Summary *(Dollars in Thousands)*	**2010-11 Revised**	**2011-12 Proposed**	**$ Change**	**% Change**
Benefits	$52,686,000	$39,438,600	-$13,247,400	-25.1%
County Administration (Eligibility)	$2,691,300	$2,717,300	$26,000	+1.0%
Fiscal Intermediaries (Claims Processing)	$281,800	$322,200	$40,400	+14.3%
Total Local Assistance	**$55,659,000**	**$42,478,000**	**-$13,181,000**	**-23.7%**
General Fund	$12,759,100	$13,842,500	$1,083,400	+8.5%
Federal Funds	$37,449,700	$25,974,500	-$11,475,200	-30.6%
Other Funds	$5,450,300	$2,661,100	-$2,789,200	-51.2%

Second, substantial cost-containment, which is being proposed for the Medi-Cal Program. The budget proposes over $2.7 billion in reductions for 2011-12 through strategies that include:

- Placing limits on health care services;
- Elimination of certain benefits;
- Cost-sharing through Medi-Cal enrollee co-payment requirements;
- Provider payment reductions;
- Additional sources of alternative funding (i.e., redirection of Proposition 10 Funds, Hospital Fee extension, increased federal funds through the new 1115 Medicaid Waiver).

The table below provides a summary of proposed reductions and cost shifts by major category. These Administration proposals are all directed at reducing General Fund expenditures in the program.

Summary Chart of Key Medi-Cal Reductions & Cost Shifts in Budget
(General Fund Solutions)

Major Category of Adjustment	Revised 2010-11 General Fund Solutions	Proposed 2011-12 General Fund Solutions
1. Reductions to Medi-Cal Enrollee Benefits (cost-sharing, limits and elimination of services)	-$6.3 million	-$994.4 million
2. Implementation of 1115 Medicaid Waiver**	-$400 million	-$500 million
3. Medi-Cal Provider Payment Reductions	-$11.5 million	-$733.6 million
4. Hospital Fee Extension: January to June 2011	-$160 million	--
5. Redirection of Proposition 10 Funds (June Ballot Measure)	--	-$1 billion
General Fund Solution Amount (Reduction)	**-$221.8 million**	**-$3.228 billion**

**Federal CMS approved California's 1115 Waiver in November 2010. The framework of this Waiver is contained in SB 208 (Steinberg), Statutes of 2010, AB 342 (Perez), Statutes of 2010, and federal Terms and Conditions. This savings level is consistent with these documents. Savings are reflected in a Non-Budget Control Item and do not totally accrue to the Medi-Cal Program directly. Some savings, which are due to the receipt of federal funds through the 1115 Medicaid Waiver, are used in certain public health programs and within the Department of Corrections.

Federal Approval Required. All of the DHCS mandatory co-payment, utilization limits, and benefit reductions are contingent on federal approval of State Plan Amendments, and in some cases federal Waivers (mandatory co-payments). State Plan Amendments are submitted for federal approval to document that California meets federal requirements set forth in law and regulation.

Federal Waivers allow States to Waive certain federal requirements generally to obtain programmatic flexibility while furthering the purposes of the Medicaid (Medi-Cal) Program. At a minimum, DHCS would need Waivers of federal laws and regulations for:

- The types of populations affected (i.e., children, pregnant women, long-term care);
- The federal poverty levels affected (including Medi-Cal enrollees with incomes below 100 percent of poverty); and
- The level of co-pay to be charged—related to both the definition of "nominal pay" and the five percent of family income per month maximum.

No other state has mandatory co-pays in its Medicaid program.

Background on Medi-Cal Benefits. The budget proposes various reductions to health care services (benefits) provided to Medi-Cal enrollees. The table below provides a summary of these proposed reductions and reflects estimated General Fund savings amounts (corresponding amounts of federal funds would be reduced as well).

The proposed reductions for benefits fall into three categories: 1) limiting access to services; 2) requiring mandatory co-payments for services; and, 3) eliminating services. Almost all of these proposals were presented last year and rejected by the Legislature; however due to the State's fiscal crisis, the Administration believes they warrant reconsideration.

Summary of Key Reductions to Medi-Cal Benefits (General Fund Component)

Proposed Reduction	Effective Date	2010-11 General Fund Reduction Amount	2011-12 General Fund Reduction Amount
1. Hard Cap: 10 Visits for Physicians & Clinics	09/01/2011	--	-$196.5 million
2. Mandatory Co-pays for Physicians & Clinics	10/01/2011	--	-$152.8 million
3. Hard Cap: 6 Prescription Outpatient Drugs	10/01/2011	--	-$11 million
4. Mandatory Co-pays for Pharmacy	10/01/2011	--	-$140.3 million
5. Mandatory Co-pays for Hospital Services, including (a) Hospital Inpatient, (b) Non-Emergency Room, and (c) Emergency Room	10/01/2011	--	-$262.8 million
6. Copayment for Dental Services *Revised Calculation*	05/01/2011	-$208,500 *-$4 million*	-$1.3 million *-$27.9 million*
7. Proposed Elimination of Over-the-Counter Cough and Cold Products	06/01/2011	-$97,000	-$2.2 million
8. Eliminate Adult Day Health Care Services	06/01/2011	-$1.7 million	-$176.6 million
9. Limit Enteral Nutrition Products for Adults to Tube Feeding Only	06/01/2011	-$547,000	-$14.5 million
10. Establishes Maximum Annual Dollar Limit for Durable Medical Equipment	10/01/2011	--	-$7.4 million
11. Establishes Maximum Annual Dollar Limit for Medical Supplies	10/01/2011	--	-$1.9 million
12. Establishes Maximum Annual Dollar Limit for Hearing Aid Expenditures	10/01/2011	--	-$507,000
TOTALS (revised calculations)		**-$6.3 million**	**-$994.4 million**

ISSUE 1: HARD CAP: 10 VISITS TO PHYSICIANS & CLINICS (ADULTS)

Budget Proposal. The budget proposes a "hard cap" of 10 office visits per year for Medi-Cal enrollees in both Medi-Cal Fee-for-Service and Medi-Cal Managed Care programs. A reduction of $392.9 million ($196.5 million General Fund) is assumed from this action.

This proposal affects outpatient primary care and specialty care provided under the direction of a Physician in the following settings:

- Hospital Outpatient Department;
- Outpatient Clinic;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Centers (RHCs); and
- Physician Offices.

DHCS states that approximately 3.3 million office visits are provided annually, and *40* percent, or 1.3 million office visits, would be above this proposed cap of 10 visits per year.

Additional Details:

- Trailer bill language is required for enactment.
- A September 1, 2011 implementation date is assumed.
- This proposal requires a State Plan Amendment and federal CMS approval.
- Consistent with federal rules, this would apply only to adults. Children (21 years and under), pregnant women, and residents in Long-Term Care facilities would be exempt.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- The Administration's "hard cap" does not take into account cost shifts to other services—such as emergency rooms and hospitalizations—that would likely occur from this action due to the lack of primary and specialty care, which would result.

- This proposal would negatively impact people with the greatest need for health care services. Individuals with HIV, AIDS, cancer, and many other serious and chronic medical conditions utilize vastly more than 10 visits per year.

- Appropriate medical care in the right setting provides for a cost-beneficial program and more positive patient health outcomes.

1. What would happen when medically fragile individuals exceed this cap?

2. Do any other States have similar caps?

ISSUE 2: HARD CAP: SIX PRESCRIPTION OUTPATIENT DRUGS

Budget Proposal. The budget proposes a "hard cap" on the *existing* six-prescription per month limit. A reduction of $22.1 million ($11 million General Fund) is assumed from this action.

Medi-Cal would not pay for prescriptions beyond the six-prescription per month limit unless Medi-Cal deems the drugs to be life-saving, such as those used for the treatment of HIV/AIDS, cancer, hypertension, diabetes, coagulation disorders and mental health disorders. The precise process for defining "life-saving drugs" remains unclear.

Additional Details:

- Trailer bill language is required for enactment.
- A October 1, 2011 implementation date is assumed.
- This proposal requires a State Plan Amendment and federal CMS approval.
- Consistent with federal rules, this would apply only to adults. Children (21 years and under), pregnant women, and residents in Long-Term Care facilities would be exempt.

Background. A six-prescription per month limit ("soft cap") for Medi-Cal enrollees became effective in 1994 and is still in effect today. Any prescription beyond this limit must receive "prior authorization" by the DHCS in order to be covered by Medi-Cal.

This existing prescription limit does not count the number of different drugs dispensed in a month, or the number of drugs a recipient is currently taking. Rather, it is a limit on pharmacy drug claim lines submitted within a calendar month. For example, if the same drug is dispensed four times a month, it counts as four of the six prescriptions. There are exemptions to this existing limit, also for "live-saving drugs."

LAO. The LOA recommends the Legislature deny this proposal.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- It is unclear how the DHCS would make its determinations with regarding to life-saving medications to be exempted from the proposed "hard cap".

- It is unclear how the DHCS would administer this proposal.

- It is unclear how Medi-Cal patients with significant health care needs would not experience additional medical problems as a result.

- This proposal does not account for cost shifts to other services—such as increased physician, clinic, or emergency room visits—that may occur if appropriate medications are not provided.

1. What impact would this policy have on people with chronic and serious health conditions?

ISSUE 3: MANDATORY CO-PAYMENTS: MD & CLINIC VISITS

Budget Proposal. The budget assumes a reduction of $305.7 million ($152.8 million General Fund) by implementing *mandatory* copayments of $5 per Physician Office visit and $5 per Clinic Office visit (FQHC and RHC clinics) at the point of service.

The Administration's reduction estimate of $305.7 million (total funds) assumes savings from both a rate reduction to Physicians and Clinics, as well as an 8 percent reduction in utilization by Medi-Cal enrollees. Specifically, about $219 million (total funds) is attributable to a rate reduction and about $86 million for less Office Visits.

Additional Details:

- There would be no exemptions to this policy. All Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included.
- Trailer bill language is required for enactment.
- An October 1, 2011 implementation date is assumed.
- This would apply to both fee-for-service and managed care.
- This proposal requires a State Plan Amendment and a federal Waiver, both of which require federal CMS approval.

Background. Under this proposal, the Physician would collect the $5 copayment at the time of service and the providers would be reimbursed their Medi-Cal rate minus the $5 copayment. If the Medi-Cal enrollee does not pay the $5 copayment, the Physician can deny the service. Currently, Medi-Cal enrollees have a voluntary $1 copayment per office visit and services cannot be denied if the enrollee does not pay.

DHCS states that the average cost of a Fee-for-Service Physician Office Visit is $82.49 and the average cost of an FQHC or RHC Clinic Visit is $140.16.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- A mandatory co-payment for physician visits and clinic visits may serve as a deterrent to obtaining cost-effective preventive medical care services.

- Mandatory co-payments may generally reduce access to health care for low-income children, families, and individuals.

- The Administration's proposal does not account for cost shifts to other services—such as emergency rooms—that would likely occur from this action.

- Physicians often view co-payments as simply a provider rate reduction given that they often will provide the care regardless of the ability or willingness of the patient to provide the co-payment.

1. How would this policy affect people with chronic or serious health conditions, and specifically what would be the impact on CCS children and families?

2. Please explain why a federal Waiver is necessary.

3. Please provide the Legislature with a fiscal analysis of a $2 co-pay, in place of the proposed $5 co-pay.

ISSUE 4: MANDATORY CO-PAYMENT: PHARMACY

Budget Proposal. The budget proposes a reduction of $280.6 million ($140.3 million General Fund) by implementing mandatory co-payments of $3 per prescription for preferred drugs (generics) and $5 per prescription for non-preferred (brand) at the point of service.

The Administration's reduction estimate of $280.6 million (total funds) assumes savings from: 1) a rate reduction to Pharmacists; 2) a 5 percent reduction in the number of prescriptions once the copayment is implemented; and 3) a shift of 25 percent from non-preferred (brand) to preferred (generics). This break out is as follows:

- $135.1 million (total funds) from Pharmacy rate reduction.
- $93.6 million (total funds) from a 5 percent reduction in the number of prescriptions.
- $51.9 million (total funds) from the 25 percent shift to preferred (generics).

The Pharmacy would collect the copayment at the point of service, and the Pharmacists would be reimbursed their Medi-Cal rate minus the $3 or $5 copayment. The mandatory co-payment means the Pharmacist can deny the Medi-Cal enrollee their prescription medication unless the co-payment is made at the point of service; hence, the anticipated 5 percent reduction in the number of prescriptions. Currently, Medi-Cal enrollees have a voluntary $1 co-payment per prescription and services cannot be denied if the Medi-Cal enrollee does not pay. The average cost of a prescription is $92.

Additional Details:

- There would be no exemptions to this policy. All Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included.
- Trailer bill language is required for enactment.
- An October 1, 2011 implementation date is assumed.
- This would apply to both fee-for-service and managed care.
- This proposal requires a State Plan Amendment and a federal Waiver, both of which require federal CMS approval.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- A mandatory co-payment for pharmacy may serve as a deterrent to obtaining medically-necessary drugs.

- The Administration's proposal does not account for cost shifts to other services—such as emergency rooms—that would likely occur from this action.

1. Please describe the impact that mandatory co-payments would likely have on people with serious or chronic conditions requiring substantial on-going medications.

ISSUE 5: MANDATORY CO-PAYMENT: HOSPITAL SERVICES

Budget Proposal. The budget proposes implementation of three mandatory co-payments related to hospital services for a total reduction of $542.1 million ($262.8 million General Fund).

Under these proposals, the Hospital collects the co-payment from the Medi-Cal enrollee as applicable. DHCS would then reimburse the Hospital the Medi-Cal rate minus the co-payment. As such, it serves as a Medi-Cal rate reduction. If the Medi-Cal enrollee cannot pay the co-payment, theoretically the hospital could deny health care services to the individual. However, the DHCS notes that hospitals must still comply with the Emergency Medical Treatment and Active Labor Act. As such, most care still would need to be provided by the hospitals.

The *three* proposed mandatory co-payments related to hospital services are as follows:

1. *Mandatory $100 Co-pay for Hospital Inpatient Days.* Medi-Cal enrollees would be required to pay $100 per Inpatient Hospital day up to a maximum of $200 per admission. This mandatory co-payment would apply to all Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women. No exemptions would be provided. The budget assumes a reduction of $319 million ($151.2 million General Fund) from this action. A significant aspect of this proposal is an assumed reduction in Hospital Inpatient admissions. Specifically, a 5 percent reduction is assumed once the co-payment is implemented, which is about 30 percent of the proposed reduction. It should be noted that only 21 percent of Medi-Cal Hospital Inpatient days are for only one day, with the remaining 78 percent for two or more days. This reflects the more medically needy population. Further, Medi-Cal's treatment authorization system and reimbursement method for Hospital Inpatient days already dissuades frequent use by Medi-Cal enrollees or Hospitals.

2. *Mandatory $50 Co-pay for Non-Emergency Room Visits.* Medi-Cal enrollees would be required to pay $50 for Non-Emergency Room use of Emergency Rooms. This mandatory co-payment would apply to all Medi-Cal enrollees. No exemptions would be provided. The budget assumes a reduction of $146.4 million ($73.2 million General Fund) from this action. For this calculation, the DHCS assumed a reduction of 8 percent in utilization once the copayment is implemented, which reflects a reduction of $22 million (total funds) in expenditures. The remaining amount—about $125 million (total funds)—would occur from the rate reduction (i.e., offset of the co-payment).

DHCS states the average cost of a Non-Emergency Room visit is $125.94. It should be noted that the federal CMS regulations provide for States to charge co-payments for Non-Emergency services provided in a Hospital Emergency Room. However, the following requirements must be met (Federal Register of May 28. 2010, page 30245):

- Patient is to receive an appropriate medical examination to determine patient has no emergency;
- Patient has access to a non-emergency services provider without the imposition of the same cost-sharing requirement;
- Hospital must coordinate a referral to the non-emergency services provider.

It is not clear from the DHCS proposal, if the above federal criteria would be met.

3. *Mandatory $50 Co-pay for Emergency Room Visits.* Medi-Cal enrollees would be required to pay $50 for emergency use of Emergency Rooms. This mandatory co-payment would apply to all Medi-Cal enrollees. No exemptions would be provided. The budget assumes a reduction of $76.7 million ($38.4 million General Fund) from this action.

The DHCS assumed a reduction of 8 percent in utilization (for both non-emergencies and actual emergencies) once the co-payment is implemented, which reflects a reduction of $10.8 million (total funds) in expenditures. The remaining amount—about $65.9 million (total funds)—would occur from the rate reduction (i.e., offset of the copayment). DHCS states the average cost of an Emergency Room visit is $143.57.

Additional Details:

- There would be no exemptions to this policy. All Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included.
- Trailer bill language is required for enactment.
- An October 1, 2011 implementation date is assumed.
- This would apply to both fee-for-service and managed care.
- This proposal requires a State Plan Amendment and a federal Waiver, both of which require federal CMS approval.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- This mandatory co-payment is for medically necessary emergency room visits when, significant, emergency medical treatment is required.

- The proposal includes no exemptions.

- These proposals do not take into account cost shifts to other services that would likely occur from this action, or that people may become more ill and require more services.

1. Please briefly explain why a federal Waiver is necessary for these mandatory co-payment proposals.

ISSUE 6: MANDATORY CO-PAYMENT: DENTAL SERVICES

Budget Proposal. The budget proposes a reduction of $417,000 ($208,000 General Fund) in the current-year, and $2.5 million ($1.3 million General Fund) in 2011-12 by implementing mandatory co-payments of $5 per Dental Office Visit at the point of service.

Under this proposal, the Dental Office would collect the co-payment at the point of service, and the Dentist would be reimbursed their Medi-Cal rate minus the $5 co-payment. The mandatory co-payment means the dentist can deny the Medi-Cal enrollee their dental service unless the co-payment is made at the point of service.

A calculation misstep occurred and the amount of the reduction should actually be $9.3 million ($4 million General Fund) in the current year and $55.8 million ($27.9 million General Fund) in 2011-12. Therefore, if adopted, this proposal would provide for a further savings of $30.4 million (General Fund) as compared to the Governor's proposed budget.

Additional Details:

- This proposal applies to Fee-for-Service and Managed Care arrangements.
- All Medi-Cal enrollees, including children, people in Long-Term Care facilities, and pregnant women are included. No exemptions.
- Trailer bill language is required for enactment.
- A May 1, 2011 implementation date is assumed.
- This proposal requires a State Plan Amendment and a federal Waiver, which both require federal CMS approval.

Background. The Adult Dental Services benefit, other than certain federally required services, was eliminated from Medi-Cal in 2009 as a cost-cutting measure. As such, most of the co-payment reduction pertains to dental services provided to children, pregnant women, and a few adults in managed care arrangements.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- It has been well documented that a lack of dental care can lead to serious health issues.

- The Administration's proposal does not take into account cost shifts to other services—such as increased physician, clinic, or emergency room visits—that may occur if appropriate dental care is not received.

- Most of this savings is primarily directed at children having to provide a co-payment.

ISSUE 7: ELIMINATION OF OVER-THE-COUNTER COUGH & COLD PRODUCTS

Budget Proposal. The budget reduces by $194,000 ($97,000 General Fund) in the current-year and $4.4 million ($2.2 million General Fund) in 2011-12 by eliminating "non-prescription" cough and cold products for adults. Specifically, these would be so called "over-the-counter" products such as Nyquil, Robitussin, Alka-Seltzer, and similar cough and cold products.

Under this proposal, Medi-Cal enrollees could choose to pay out-of-pocket for these cough and cold products, or seek medical attention and obtain a prescription product as medically necessary. Prescription drug products are not affected by this proposal.

Additional Details:

- Trailer bill language is required for enactment.
- A June 2011 implementation date is assumed.
- Over-the-counter cough and cold products for children would remain unchanged (i.e., available through Medi-Cal). The DHCS notes that in order to be covered by Medi-Cal, even over-the-counter products for children require a prescription from a physician.

LAO. The LAO recommends adoption of this proposal.

ISSUE 8: ELIMINATION OF ADULT DAY HEALTH CARE

Budget Proposal. The budget assumes elimination of Adult Day Health Care Services (ADHC) for a reduction of $3.4 million ($1.7 million General Fund) in the current-year, and $353.2 million ($176.6 million General Fund) in 2011-12.

Additional Details:

- Trailer bill language is required for enactment.
- Assumes a June 1, 2011 implementation date.

Background. Under federal Medicaid law, ADHC services are considered "Optional" benefits for States to provide. California is one of approximately 8 states that offer ADHCS services in a bundled, day-care type setting. Nearly all states offer ADHCS services, but most in a more traditional "out-patient" setting where each service is provided individually and in different locations depending on the appropriate provider.

In California, ADHC services are a community-based day program providing health, therapeutic and social services designed to serve those at risk of being placed in a nursing home. There are approximately 325 active ADHC providers in Medi-Cal who serve about 27,000 average monthly users. The estimated cost per ADHC beneficiary is $1,128 per month, or $13,536 annually.

The DHCS states that other similar Medi-Cal services would still be available if ADHC services were eliminated, including:

- Home Health Services;
- In-Home Supportive Services;
- Physical and occupational therapy;
- Clinic services that would include dietitian, physician, social worker and nursing services; and
- Physician Services through the individual's medical health care provider.

Previous cost-containment efforts regarding ADHC services have included the following:

- *Moratorium*. In 2004, a statutory moratorium as directed by the DHCS was placed on the expansion of ADHC providers. This remains in place and only the Director of the DHCS has the discretion to add more providers.

- *Treatment Authorization Reviews (TARS)*. In 2009, on-site treatment authorization reviews were implemented and are anticipated to reduce expenditures by $1.6 million ($824,000 General Fund) in 2011-12.

- *Medical Acuity Eligibility Criteria—Enjoined by Court.* In 2009, trailer bill legislation enacted specific medical acuity eligibility criteria. The intent of this action was to focus ADHC services on the most medically acute individuals. The DHCS has estimated this would reduce expenditures by about 20 percent. This action was enjoined by the court (in the case of Brantley v Director Maxwell-Jolly, superseded by Carry Cota, et. Al v Maxwell-Jolly). The State has filed an appeal.

- *Limit ADHC Benefits to Three-Days per Week—Enjoined by Court.* In 2009, trailer bill legislation limited the number of days an individual could receive ADHC services to three days per week, except for individuals with developmental disabilities receiving services through Regional Centers (these individuals were not limited). This action was enjoined by the court (in the case of Brantley v Director Maxwell-Jolly). The State is not intending to file an appeal.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- The proposed budget includes $16 million in increased costs in the Department of Developmental Services budget, in order to continue providing these or equivalent services to the developmentally disabled population, as required under the Lanterman Act; however, the proposal does not account for any other cost-shifts to nursing home or other types of care, which would be certain and necessary for this population.

- ADHC was created to be a cost-saving measure by keeping people out of more expensive nursing homes.

- Elimination of ADHC services would have significant impacts on not just the beneficiaries, but also their families, relatives and other caretakers, and the thousands of people who work at ADHCs.

1. Is it possible to reduce provider rates just for ADHC services, without implementing an across the board provider rate reduction throughout Medi-Cal?

ISSUE 9: LIMIT ENTERAL NUTRITION PRODUCTS FOR ADULTS TO TUBE-FED

Budget Proposal. The budget reflects a reduction of $1.1 million ($547,000 General Fund) in the current-year and $28.9 million ($14.5 million General Fund) in 2011-12 through enactment of trailer bill language to limit Enteral Nutrition products provided to Adults.

Specifically, these products would only be provided for those adults who must be tube-fed. Conditions, which require tube feeding, include but are not limited to, anatomical defects of the digestive tract or neuromuscular diseases.

DHCS states that a product may be exempted from their proposed limit when used as part of a therapeutic regimen for patients with conditions for which regular food, or standard processed foods, cannot be consumed without causing risk to the health of the patient.

Additional Details:

- Trailer bill would be required for enactment.
- An implementation date of June 1, 2011 is assumed.
- Children, pregnant women, and individuals in Long-Term Care facilities would be exempt from this limitation.

Background. Under federal law, Enteral Nutrition products are a Medicaid "optional" benefit. The DHCS states this proposal would align Medi-Cal with the current Medicare benefit, which limits these products to those individuals who are tube fed.

Currently, Medi-Cal Enteral Nutrition products are covered only when supplied by a Pharmacy provider upon the prescription of a licensed practitioner within the scope of their practice. All Enteral Nutrition products require prior authorization for Medi-Cal reimbursement.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- It is unclear specifically which medically-needy individuals would be exempted or how this process would be determined and administered.

1. Under what circumstances do people use these products when it is not medically-necessary?

ISSUE 10: MAXIMUM ANNUAL CAP: DURABLE MEDICAL EQUIPMENT

Budget Proposal. The budget assumes a reduction of $14.7 million ($7.4 million General Fund) through enactment of trailer bill legislation to cap the maximum expenditures per Medi-Cal enrollee for Durable Medical Equipment (DME). The maximum dollar limit would be $1,604 annually per Medi-Cal enrollee. The only DME products exempt from the proposed dollar limit are Respiratory and Oxygen equipment.

Additional Details:

- An implementation date of October 1, 2011 is assumed.
- This proposal requires a State Plan Amendment and federal CMS approval for implementation.
- DHCS states this DME limit would apply to adults (21 years and older) who are not in Long-Term Care Facilities or pregnant women. Children (21 years and under) and Pregnant women are exempt.

Background. DME items include ambulation devices (such as walkers), bathroom equipment, decubitus (bedsore) care equipment, hospital beds and accessories, patient lifts, traction and trapeze equipment, communication devices, IV equipment, oxygen and respiratory equipment, and wheelchairs and accessories.

DHCS contends their proposed DME limit would enable 90 percent of the Medi-Cal population to continue to receive all necessary DME products because they are presently at or below the proposed dollar limit of $1,604 per enrollee. Excluding those exempt from the budget proposal, this 90 percent consists of about 60,100 Adult DME users with expenditures of $11.7 million (total funds).

In comparison, the DHCS states that 6,773 people, or about 10 percent of those needing DME products, would exceed the limit. These individuals have an average cost of $4,666 annually, or almost 3 times the amount of the proposed dollar limit. Specifically, this 10 percent comprises 70 percent of the total costs with expenditures of $31.6 million (total funds).

Under federal law, DME products are considered a Medicaid “optional” benefit. Medi-Cal has covered DME products since 1988.

LAO. The LAO recommends adoption of this proposal.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- A key concern with this limit is for people who require a combination of DME products due to their fragile medical state, as well as people who need more costly customized wheelchairs in order to live independently and to be mobile (access to school, work and quality of life issues).

- The Administration's proposal does not take into consideration any cost shifts to other services—such as Physician visits, clinic visits, or emergency rooms—that may occur if appropriate DME products are not provided.

- It does not take into account cost shifts to the Department of Developmental Services for the provision of DME products needed for people who are clients of the Regional Center system and entitled to services.

- The trailer bill language has not yet been provided by the Administration; however, the proposed language from last year contained a specified dollar amount for the hard cap. As such, legislation would be necessary to change them in the future which would be quite challenging

1. Please briefly describe the people who would be affected by the dollar limit.

2. Do we know why they are higher-need users of these products (or which products)?

3. What is the average or typical cost of a customized, motorized wheel-chair, and a speech-generating device?

ISSUE 11: MAXIMUM ANNUAL CAP: MEDICAL SUPPLIES

Budget Proposal. The budget proposes a reduction of $3.9 million ($1.9 million General Fund) to cap the maximum expenditures per Medi-Cal enrollee for certain Medical Supplies. The annual dollar limit would apply to wound dressings, incontinence products, and urinary catheters. The table below lists the proposed annual dollar limits. The annual limit is based on a State fiscal year, not a calendar year.

Table: Proposal to Limit Medical Supplies

Medical Supply Item to be Capped	Proposed Annual Dollar Limit	People Affected by Limit (10 Percent)
Wound Care	$391	882
Incontinence Supplies	$1,659	9,050
Urologicals--catheters	$6,435	459
TOTAL		**10,391**

DHCS contends their proposed Medical Supply limit would enable 90 percent of the Medi-Cal population to continue to receive all necessary Medical Supplies because they are presently at or below the proposed dollar limits as shown in the table above.

In comparison, the DHCS states 10,391 people, or about 10 percent of those needing Medical Supplies, would exceed the limit. These individuals have average costs as follows:

- $1,191 for Wound Care as compared to the $391 proposed limit, or over 3 times the limit.
- $1,872 for Incontinence Supplies as compared to the $1,659 proposed limit.
- $7,295 for Urological supplies as compared to the $6,435 proposed limit.

Additional Details:

- Trailer bill legislation is necessary for enactment.
- An implementation date of October 1, 2011 is assumed.
- This proposal requires a State Plan Amendment and federal CMS approval.
- This DME limit would apply to adults (21 years and older) who are not in Long-Term Care Facilities. Children and pregnant women are exempt from the proposed limit.

Background. Federal law considers Medical Supplies to be an Optional benefit. Medi-Cal has included Medical Supplies in its program since 1976. Currently, Medical supplies are a benefit in Medi-Cal when prescribed by a Physician. Certain prior authorization approvals also apply. In addition, the DHCS has authority to contract with providers for certain supplies, including incontinence supplies.

LAO. The LAO recommends adoption of this proposal.

STAFF COMMENTS & QUESTIONS

Key issues for consideration:

- The Administration's proposal does not take into consideration any cost shifts to other services—such as Physician visits, clinic visits, or emergency rooms—that may occur from this action.

- The people who fall outside of the 90th percentile are people who have significant medical conditions. Without these medical supplies, it is likely that infections and other more severe medical conditions will occur.

- The trailer bill language has not yet been provided by the Administration; however, the proposed language from last year contained a specified dollar amount for the hard cap. As such, legislation would be necessary to change them in the future, which would be quite challenging.

1. What types of conditions would cause people to exceed the proposed annual limit?

ISSUE 12: MAXIMUM ANNUAL CAP: HEARING AIDS

Budget Proposal. The budget proposes a reduction of $1 million ($507,000 General Fund) through enactment of trailer bill legislation to cap the maximum expenditures per Medi-Cal enrollee for hearing aid expenditures. The maximum dollar limit would be $1,510 annually per Medi-Cal enrollee. This includes expenditures for the Hearing Aid, ear molds, and repairs.

DHCS contends the expenditure limit would enable 90 percent of the Medi-Cal population to continue to receive Hearing Aids and most servicing of the devices because they are presently at or below the proposed expenditure limit of $1,510 per enrollee.

Additional Details:

- An implementation date of October 1, 2011 is assumed.
- This proposal requires a State Plan Amendment and federal CMS approval for implementation.
- This limit would apply to adults (21 years and older) who are not in long-term care facilities. Pregnant women would be exempt.

Background. Medi-Cal reimbursement for Hearing Aids varies but the maximum reimbursement for the device is $884 (monaural) and $1,480 (binaural). In addition to the device, many people also need ear molds.

According to DHCS data, there would be 2,293 people above the proposed expenditure limit. The average amount expended by this 10^{th} percentile group is $1,579 annually, or about $80 higher than the proposed cap. The DHCS states that by and large this group exceeds the proposed cap by being provided “top of the line” hearing aids.

Federal law considers Hearing Aids to be an Optional benefit. Medi-Cal has included Hearing Aids in its program since 1988. Hearing Aids are a benefit in Medi-Cal when supplied by a Hearing Aid Dispenser through the prescription of Otolaryngologist or attending Physician.

STAFF COMMENTS & QUESTIONS

The following language (Welfare & Institutions Code Section 14105.3 (e)) was adopted in the 2006 budget trailer bill to help the State save money on the provision of hearing aids in the Medi-Cal program. According to the DHCS, this has never been implemented.

> (e) In order to ensure and improve access by Medi-Cal beneficiaries to both hearing aid appliances and provider services, and to ensure that the state obtains the most favorable prices, the department, by June 30, 2008, shall enter into exclusive or nonexclusive contracts, on a bid or negotiated basis, for purchasing hearing aid appliances.

1. Please explain the history of this and the reasons that it has never been implemented?

2. Does the Administration believe that this could be a viable alternative savings proposal to the annual cap on hearing aids or medical supplies?

ISSUE 13: PROVIDER RATE REDUCTIONS

Budget Proposal. The budget reflects a reduction of $18.2 million ($9.4 million General Fund) in the current-year and $1.1 billion ($537.1 million General Fund) in 2011-12 through enactment of Medi-Cal Provider Payment reductions.

The Provider Payment reductions vary by Provider Type, due to Provider Payment reductions enacted in prior years, which were enjoined by various Court actions and then partially restored. As such, the budget proposes to enact an additional percentage reduction that varies depending on this history. The general intent of the Provider Payment reductions as contained in the budget is to reflect an overall 10 percent ongoing Provider Payment reduction.

It should also be noted that a calculation misstep is in the Medi-Cal budget and a 10 percent Provider Payment reduction for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD Facilities) should have been included for a reduction of $41.1 million ($20.5 million General Fund) for these facilities.

Additional Details:

- An implementation date of June 1, 2011 is assumed.
- This proposal requires a State Plan Amendment and federal CMS approval.
- The proposed Provider Payment reductions are applicable to both Fee-for-Service and Managed Care providers.

Background. Medi-Cal Provider Payments are some of the lowest in the United States. Federal law requires Medicaid payments (Medi-Cal in CA) to be sufficient to enlist providers so that care and services are available to the extent that such care and services are available to the general public in a geographic region. Concerns regarding Medi-Cal enrollee access to health care services, including various specialists, have been of concern in the past in California.

There is a long history of legal challenges and actions regarding the various methodologies used in developing Medi-Cal Provider Payments, as well as the various reductions, which have been enacted over the past few years.

The United States Supreme Court recently agreed to hear California's appeal of a Ninth Circuit Court of Appeals ruling involving Medi-Cal's Provider Payments. This involves three cases: 1) Director Maxwell Jolly v. Independent Living Center; 2) Director Maxwell Jolly v. California Pharmacists Association; and 3) Director Maxwell Jolly v. Santa Rosa Memorial Hospital. It is anticipated the United States Supreme Court will provide its decision by late Fall 2011. The key issue is whether the Supremacy Clause of the Constitution confers a private right of action on providers and Medicaid enrollees to challenge rates for compliance with certain federal law.

STAFF COMMENTS & QUESTIONS

1. Please provide a brief summary, including of the U.S. Supreme Court hearing California's case and when a ruling may occur.

2. Please explain the Administration's confidence that this rate reduction would prevail in future litigation, as compared to prior rate reductions.

3. Please clarify exactly which hospitals would be subject to this rate reduction. Critical Access Hospitals?

ISSUE 14: PROVIDER RATE REDUCTIONS: NURSING HOMES

Budget Proposal. The budget reflects a reduction of $4.6 million ($2.3 million General Fund) in the current-year and $392.9 million ($172 million General Fund and $24 million Quality Assurance Fee) in 2011-12 through enactment of a 10 percent Provider Payment reduction to Nursing Homes (Level B's).

As referenced below, Nursing Home (Level B) facilities are reimbursed using methodology established under AB 1629, Statutes of 2004. This methodology uses General Fund support, coupled with Quality Assurance Fees (QA Fees), to obtain federal matching funds. As required under the methodology, each Nursing Home has an individual facility specific rate based upon previous cost reports, which reflect labor and operations expenditures.

Under existing statute, these Nursing Homes are to receive an average 3.93 percent rate adjustment for 2010-11 and an average 2.4 percent adjustment for 2011-12. The DHCS states the proposed budget reduction of 10 percent to the Provider Payment would be applied to a Nursing Home's bottom-line, after the existing statutory rate adjustments (average of 3.93 and average of 2.4) are calculated.

Additional Details:

- An implementation date of June 1, 2011 is assumed.
- This proposal requires a State Plan Amendment and federal CMS approval.

Background—Nursing Home Reimbursement (AB 1629, Statute of 2004). Certain Nursing Home rates are reimbursed under Medi-Cal using combinations of federal funds, General Fund, and revenues collected from Quality Assurance Fees (QA Fee). Use of QA Fees has enabled California to provide reimbursement increases to certain Nursing Homes with no added General Fund support.

This existing reimbursement method established under AB 1629, Statues of 2004, requires the DHCS to implement a facility-specific rate system for certain Nursing Homes and it established the QA Fee. Revenue generated from the QA Fee is used to draw federal funds and provide additional reimbursement to Nursing Homes for quality improvement efforts. The current QA Fee structure sunsets on July 31, 2012. If the QA Fee sunsets, over $400 million in General Fund support is at risk.

Summary of Budget Act of 2010 Actions. Through the Budget Act of 2010 and corresponding trailer bill (SB 853, Statutes of 2010), a comprehensive Nursing Home Quality and Accountability package was adopted and contained the following *key* components:

- *Rate Adjustments*. Provides for a two-year rate adjustment of 3.93 percent increase in 2010-11 and up to 2.4 percent in 2011-12 by extending the sunset of the Quality Assurance Fee to July 31, 2012.

- *Quality & Accountability.* Begins to phase-in a Quality and Accountability system by establishing a special fund and a reward system for achieving certain measures. A comprehensive stakeholder process will be used by the Administration to proceed with implementation of this system and to publish specific information. A special fund was established for supplemental payments to be made under this system. Penalty collections will also be deposited into this special fund. Supplemental payments for 2011-12 are anticipated to be $50.9 million (total funds).

- *Compliance with 3.2 Nursing Ratio.* Required the State to audit nursing homes for complying with the existing 3.2 nursing hours to patient ratio. Nursing homes who are non-compliant from 5 percent to 49 percent of audited days would be assessed a penalty of $15,000. This increases to $30,000 for those who are non-compliant from 50 percent or more of audited days.

- *Legal Costs and Liability.* Limited legal costs incurred by nursing homes engaged in the defense of legal actions filed by governmental agencies or departments against the facilities. In addition, it limits Medi-Cal reimbursement for liability insurance to the 75th percentile computed on a geographic basis.

- *Expanded the Quality Assurance Fee.* Expanded the Quality Assurance Fee to include Multi-Level Retirement Communities as proposed by the Administration since Medi-Cal pays for over 50 percent of these facilities patients.

STAFF COMMENTS & QUESTIONS

Based on information received to date, it is unknown how the budget proposal may affect quality and accountability aspects at the Nursing Homes or unravel efforts made last year to improve the system overall.

In addition, the Quality Assurance Fee sunsets as of July 31, 2012 and will need to be extended, or else up to $400 million in General Fund support could be jeopardized. It is unknown how the Administration's proposal could affect this issue.

1. Please provide a brief summary of the proposal, including how the reduction would be applied, the interactions with the updated quality assurance changes from last year, as well as how the reduction affects the Quality Assurance Fee.

2. Could this proposed reduction be affected by the pending U.S. Supreme Court review regarding California's Medi-Cal reimbursement?

ISSUE 15: FEDERAL ROGER'S AMENDMENT

Budget Proposal. The Administration proposes a reduction of $6.4 million (General Fund) by extending the sunset date of Section 14091.3 of the Welfare and Institutions Code by one-year (to January 2013).

Specifically, this code section is based on federal law and regulation (known as the Roger's Amendment) that requires State Medicaid Programs to establish separate payment amounts for emergency services and post-stabilization services.

The intent of the law is to establish a basis for Managed Care Plans to make reasonable payments to Hospitals that are "out-of-network" for these services. Historically, some Hospitals have litigated payments from Managed Care Plans that were high enough for the federal CMS to determine them to be unreasonable for the services provided.

ISSUE 16: MEDI-CAL MANAGED CARE TAX

Budget Proposal. The Administration proposes to permanently establish the existing tax on the total operating revenue of Medi-Cal Managed Care Plans as originally enacted in AB 1422, Statutes of 2009. Existing statute sunsets as of July 1, 2011.

The budget projects revenues of $194.5 million to be generated in 2011-12 from this tax. Revenues from this tax are matched with federal funds and are used to: 1) provide a reimbursement rate increase to Medi-Cal Managed Care Plans; and 2) fund health care coverage for children in the Healthy Families Program.

For the Medi-Cal Program, half of the generated revenues, or $97.2 million, will be matched with federal funds to provide for capitation payments. A total of $194.4 million (total funds) is available for this purpose. These funds are necessary in order to keep the participating plans whole.

Based upon a revised Fund Condition analysis, it has been determined that an additional $89.9 million in Special Fund support is available to offset (save) General Fund support in 2011-12 above the Governor's proposed January budget. This is because in 2009-2010, General Fund support was used to provide for a transition period while the new tax revenue was being obtained from the Medi-Cal Managed Care Health Plans. Therefore, there was an unexpended balance in the Special Fund that can be used to offset General Fund for Medi-Cal Managed Care rates. This meets existing statutory requirements for expenditure of these revenues. The table below displays this information.

Summary Table: Children's Health and Human Services Fund (Medi-Cal Managed Care Plan Tax Revenues)

	2009-10	2010-11	2011-12
Beginning Balance	$0	$152.2 million	$0
Revenues, Transfers, Adjustments	$234 million	$192.3 million	$194.5 million
Total Revenues, Transfers, and Adjustments	**$234 million**	**$344.5 million**	**$194.5 million**
Expenditures:			
MRMIB	$81.8 million	$177.1 million	$97.2 million
DHCS	$0	$77.5 million	$97.2 million
Total Expenditures	**$81.8 million**	**$254.6 million**	**$194.5 million**
Balance Remaining	$152.2 million	$0	$0
Additional Available to Offset General Fund to DHCS		**$89.9 million**	

Constituency Concerns. Managed Care Plans have expressed their support for continuation of the tax established under AB 1422 but are seeking a sunset in lieu of the Administration's proposal for permanently establishing the tax. They note the federal CMS is reviewing California's methodology for the tax and that federal funding formulas will be evolving in 2014 forward with implementation of the federal Affordable Care Act and reauthorization of the State Children's Insurance Program (Healthy Families in CA).

ISSUE 17: BUDGET CHANGE PROPOSALS

Department of Health Care Services Budget Change Proposals			
Positions Requested	**Cost**	**Fund Source**	**Description**
BCP #1 (HC11-03) Convert to permanent 2.0 existing limited-term positions	$211,000 in 2011-12 and ongoing	Mental Health Services Act (MHSA, Prop 63) and federal matching funds	To authorize DHCS to make permanent two limited-term positions to support the ongoing workload of overseeing the Medi-Cal Specialty Mental health Services Waiver program in response to both federal CMS and state OSAE audits which require expanded oversight and monitoring of the Wavier to increase fiscal integrity, improve accounting and reimbursement and claims processing.
BCP #2 (HC11-04) 19.0 new permanent positions	$1.1 million in CY and $1.9 million in BY and ongoing	CDCR budget savings and Federal Funds	To authorize DHCS to facilitate federal Medicaid claiming for inpatient hospital services for adult inmates of state correctional facilities who are eligible for either Medi-Cal or local Coverage Expansion and Enrollment Demonstration (CEED) projects. The purpose of this is to save General Fund dollars by acquiring a federal Medicaid match for services that the state currently pays for solely with General Fund. Savings will depend on the number of eligible inmates, which is still being assessed by the Department of Corrections and Rehabilitation. The new positions are needed to implement new policies and procedures, oversee and conduct eligibility determinations for inmates, and develop mechanisms to follow federal policies to obtain federal reimbursement.

BCP #3 (HC11-05) 3-year extension for 5 existing limited-term positions	$631,000 in 2011-12 and ongoing	MHSA/Prop 63 funds and federal funds	To give DHCS expenditure authority and extend limited-term positions associated with the California Mental Health Care Management Program (CalMEND). CalMEND seeks to improve outcomes and reduce costs for Medi-Cal beneficiaries with Serious Mental Illness, Serious Emotional Disturbance, or Substance Use. The program has recently expanded to include two large healthcare improvement pilots.
BCP #4 (HC11-07) 2.5 new permanent positions	$257,000 in 2011-12 and $251,000 in 2012-13	Reimbursement of .2% of IGT revenue	To give DHCS expenditure authority for new positions to support increased workload associated with increased participation by counties and local health plans in the Intergovernmental Transfer (IGT) Program, resulting from Medi-Cal Managed Care expanding. Only two health plans/counties participated in 2008-09 and participation is expected to increase to 18 counties and 36 health plans. LA County has requested that its IGTs be performed twice each year.
BCP #5 (HC11-08) 16.0 new 2-year limited-term positions	$2.2 million in 2011-12 and $2.1 million in 2012-13	90% federal funds (ARRA grant) and 10% from the California Health Care Foundation	To give DCHS expenditure authority for new positions and a contract (for EHR expertise) for planning and implementing the Medi-Cal Electronic Health Record Incentive Program. This federal American Recovery and Reinvestment Act (ARRA) grant is to provide incentive payments to qualified health care providers who adopt and use electronic health records. The DHCS expects the Medi-Cal EHR Incentive Program to bring as much as $1.4 billion in federal funds to the state between now and 2021. An assessment identified 435 hospitals and more than 10,000 Medi-Cal providers who qualify to receive incentive payments, which will be 100 percent federally funded based on statutorily-defined formulas.

BCP #6 (HC11-09) 17.0 new 2-year limited-term positions	$2 million in 2011-12 and 2012-13	**General Fund** ($949,000) and Federal Funds ($1,095,000)	To give DHCS expenditure authority and new positions to support the increased workload associated with mandatory provisions of federal health care reform that require numerous, complex changes in the Medi-Cal program. Specifically, these positions will implement: changes to handling of manufacturer drug rebates; changes to Medi-Cal eligibility, benefit, and payment modifications; and interaction between Medi-Cal eligibility and the Health Benefit Exchange. DHCS states that it cannot redirect existing positions for this purpose.
BCP #7 (HC11-13) 11.0 new 2-year limited-term positions	$1.2 million in both 2011-12 and 2012-13	**General Fund** ($480,000) and Federal Funds ($724,000) in 2011-12 and similar amounts in 2012-13	To give DHCS expenditure authority and new positions to develop and implement, on an accelerated basis, the new Diagnosis-Related Groups (DRG) payment system for hospital inpatient services adopted in last year's budget trailer bill. The DRG payment system is expected to save the state money once implemented by paying hospitals the average cost of treating patients in the same DRG. These positions will: develop the methodology; assess current hospital inpatient payments; identify necessary operational and systems changes; develop DRG rates; perform audits; and more.
BCP #8 (HC11-14) 23.0 new 3-year limited-term positions	$1.9 million CY $4.3 million BY $4.3 million BY+1	Local and Federal Funds	To give DHCS expenditure authority for positions and contracts to implement the local Coverage Expansion and Enrollment Demonstration (CEED) projects created through AB 342 (Perez, Statutes of 2010) a part of the new Medi-Cal 1115 waiver. The CEED Project will provide health care services to uninsured adults, 19-64 years old, who would not otherwise be eligible for Medicare or Medi-Cal, with incomes up to 133% FPL. The CEED Project is expected to save the state money in the long run by reducing the rate of growth in health care costs by using capitated

			and/or risk adjusted rate methodologies.
BCP #9 (HC11-15) 30.0 new limited-term positions	$2.5 million CY $5.1 million BY $5.1 million BY+1	Local and federal funds	To give DHCS expenditure authority, positions, and contracting authority to implement the provisions of SB 208 (Steinberg, Statutes of 2010) which contained the new Medi-Cal 1115 waiver, excluding the CEED Project. The new positions would implement SB 208 provisions related to: expanding the Safety Net Care Pool; technical changes to the Hospital Quality Assurance Fee; requiring seniors and people with disabilities to receive care through Medi-Cal managed care plans; permitting use of IGTs; and Delivery System Reform Incentive Pool (DSRIP).
BCP #10 (PS11-01) 2-year extension of 3.0 existing limited-term positions	$299,000 in 2011-12 and 2012-13	**General Fund** ($150,000) and Federal funds ($149,000)	To give DHCS (Office of HIPAA Compliance) expenditure authority and positions to address increased workload related to maintaining and improving compliance with federal and state privacy-related statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), ARRA Health Information Technology for Economic an Clinical health Act (ARRA-HITECH), and the state Information Practices Act (IPA).
BCP #11 (PS11-03) 1.0 2-year limited-term Administrative Law Judge	$165,000 in 2011-12 and $163,000 in 2012-13	Reimbursement from CDPH with federal WIC funds	To give DHCS Office of Administrative Hearings and Appeals (OAHA) expenditure authority and one new Administrative Law Judge position.